TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PINE CREEK MEDICAL CENTER

MFDR Tracking Number
M4-18-0213-01

MFDR Date Received
September 25, 2017

Respondent Name
MERGED SAFEGUARD INSURANCE CO

Carrier's Austin Representative
Box Number 11

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim... was denied on 6/27/17 for not having authorization. The treatment that was rendered was to confirm that the patient is continuing to take his medication. I am seeking assistance in getting this claim paid."

Amount in Dispute: $182.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...the Provider was notified that the Carrier believed that, under the facts reflected in the medical records, repeated urine drug screens were not medically necessary and were services that exceeded the limitations of the ODG."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
June 8, 2017	Rev Code 300 and 301 (CPT Codes 36415 and 80305)	$182.00	$18.05

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code §134.203 sets out the sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - RC 03 – This procedure or supply requires prior authorization or approval
   - 197 – Precertification/authorization/notification absent

Issues

1. Does the respondent's position statement address only the denial reasons presented to the requestor prior to the date the request for MFDR was filed?
2. Did the requestor obtain preauthorization for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed CPT Codes 36415 and 80305 rendered on June 8, 2017. The insurance carrier denied the disputed services with denial reduction codes, "RC 03 – This procedure or supply requires prior authorization or approval," and "197 – Precertification/authorization/notification absent."

   The insurance carrier in the position summary states in pertinent part, "...repeated urine drug screens were not medically necessary ..."

   28 Texas Administrative Code §133.307(d)(2)(F) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   The respondent submitted a position summary containing new denial reasons. The additional denial reasons identified on the position summary, "So, while also being denied for lack of medical necessity per Utilization review, the services also required preauthorization." The respondent submitted insufficient information to MFDR to support that the submitted denial reasons raised in their position summary were presented to the requestor or that the requestor had otherwise been informed of these new denial reasons or defenses prior to the date that the request for medical fee dispute resolution was filed with the Division; therefore, the Division concludes that the respondent has waived the right to raise such additional denial reasons or defenses. Any newly raised denial reasons or defenses shall not be considered in this review. The division will therefore review the denial reason codes presented to the requestor prior to the filing of the medical fee dispute resolution request.
2. The requestor seeks reimbursement for CPT Codes 36415 and 80305 rendered in a facility setting and billed with "bill type 131." 28 Texas Administrative Code §134.600(p)(12) states in pertinent part "(p) Non-emergency health care requiring preauthorization includes: (12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits."

   Per 28 Texas Administrative Code (TAC) §137.100 (a) states, in pertinent part, that "Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp..."* Health care provided in accordance with the Division treatment guidelines is presumed reasonable as specified in Labor Code §413.017, and is also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a). Review of the 2017 ODG pain chapter under the "Drug testing" finds that drug testing is recommended.

   The division concludes that the services were provided in accordance with the division's treatment guidelines; that the services are presumed reasonable pursuant to 28 Texas Administrative Code §137.100(c), and Labor Code §413.017; and are also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a).

   28 Texas Administrative Code §134.600(c) (1) (B) states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur... (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care..."

   The Division finds that the insurance carrier's denial reason is not supported. The requestor is therefore entitled to reimbursement for the disputed services.
3. The requestor seeks reimbursement for services rendered in a facility, bill type 131. 28 Texas Administrative Code §134.403 states in pertinent part "(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c)."

   28 Texas Administrative Code §134.203(e) states, "The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and (2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service."

The maximum allowable reimbursement(MAR) for the services in dispute is 125% of the fee listed for the codes in the 2017 Clinical Diagnostic Laboratory Fee Schedule found on the Centers for Medicare and Medicaid Services website at http://www.cms.gov. The total MAR is calculated as follows:

- Procedure code 36415, June 8, 2017, represents a lab service paid per Rule §134.203(e). The Medicare Clinical Lab Fee is $3.00. 125% of this amount is $3.75. Therefore, this amount is recommended.
- Procedure code 80305, June 8, 2017, represents a lab service paid per Rule §134.203(e). The Medicare Clinical Lab Fee is $11.44. 125% of this amount is $14.30. Therefore, this amount is recommended.

4. Review of the submitted documentation finds that the requestor is entitled to reimbursement in the amount of $18.05. As a result, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $18.05

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $18.05 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 20, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.